# HCFA LEGISLATIVE SUMMARY

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## THE MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

On December 13, 1989, the President signed into law H.R. 3607, the Medicare Catastrophic Coverage Repeal Act of 1989, Public Law 101-234. This new law repeals the major expansions of the Medicare program enacted the previous year.

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# THE MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989
## Public Law 101-234

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**MEDICARE CATASTROPHIC COVERAGE REPEAL ACT (MCCRA) OF 1989**

**Public Law 101-234**

## TITLE I -- PROVISIONS RELATING TO PART A OF THE MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

### Repeal of Expansion of Medicare Part A Benefits (Section 101)

Current Law

- Hospital and Skilled Nursing Facility (SNF) Services - There is no limit on the number of Medicare covered hospital days. Medicare covers 150 days of SNF care per calendar year. There is no prior hospitalization requirement for SNF services.

- Deductibles and Coinsurances - Beneficiaries are liable for one inpatient hospital deductible per year. No coinsurance amounts apply for inpatient hospital services. Beneficiaries are responsible for coinsurance equal to 20 percent of the national average per diem reasonable cost for the first eight days of SNF care.

- Hospice Care - Medicare covers an indefinite period of hospice care, provided a physician certifies that the patient is terminally ill.

- The spell of illness concept is not employed.

- Adjustments in Payments for Inpatient Hospital Services - For PPS hospitals, the Secretary is required to take into consideration reductions in payments to hospitals by Medicare beneficiaries resulting from elimination of the day limitation on Medicare inpatient hospital services when determining outlier cutoff points and weighting factors under PPS for discharges occurring on or after October 1, 1988.

  For PPS-exempt hospitals, the Secretary is required to take into consideration the reductions in payments to hospitals by Medicare beneficiaries resulting from the elimination of the day limitation on Medicare inpatient hospital services for cost reporting periods beginning October 1, 1988.

Provisions

- General Repeal - All Medicare Part A benefits added or expanded by MCCA (including unlimited hospital days, expansion of Medicare covered SNF services to 150 days, elimination of the three day prior hospitalization requirement for Medicare

covered SNF services, and extension of hospice coverage) are repealed.

Medicare Part A benefits revert back to those benefits in effect on December 31, 1988, including:

Limit on Inpatient Hospital Days -- A beneficiary is entitled to 90 days of inpatient hospital services during each spell of illness. An additional 60-day lifetime reserve may be used if an individual exceeds the 90-day limit.

Extended Care Services -- Medicare covers up to 100 days of SNF care during any spell of illness. Medicare-covered SNF care generally must be received within 30 days of a hospital stay of at least 3 consecutive days, and the SNF care must be for the same condition as the hospital care.

Hospice Care -- Medicare covers two periods of 90 days each and one subsequent period of 30 days.

- o Deductibles and Coinsurance - Beneficiaries are required to pay for one hospital deductible per spell of illness ($592 in 1990). Beneficiaries are liable for daily coinsurance charges equal to one-quarter of the inpatient hospital deductible ($148 in 1990) for days 61-90 in a spell of illness. The coinsurance for the subsequent 60 lifetime reserve days is equal to one-half of the inpatient hospital deductible ($296 in 1990).

  For Medicare-covered SNF services, beneficiaries are responsible for daily coinsurance equal to one-eighth of the inpatient hospital deductible for days 21-100 during a spell of illness ($74 in 1990).

- o Exception for Blood Deductible - The blood deductible will remain on a calendar year basis. A beneficiary's liability for the deductible under Part A will continue to be reduced by blood deductible pints credited under Part B, and a beneficiary's liability for the deductible under Part B will continue to be reduced by blood deductible pints credited under Part A.

- o Transition Provisions for Inpatient Hospital and Post-Hospital Extended Care Services

  The **spell of illness** concept is reinstituted. No day before January 1, 1990 is counted as part of a spell of illness. An individual's lifetime reserve days are those days that are available on January 1, 1989; that is, any lifetime reserve days used before January 1, 1989 carry over as "used" days on January 1, 1990.

The following beneficiaries would not be subject to the **inpatient hospital deductible:**

-- Individuals who paid an inpatient hospital deductible in 1989 and who are receiving inpatient hospital care on January 1, 1990 as part of a continuous period of hospitalization which began before that date;

-- Individuals who start a spell of illness during January 1990, after having paid an inpatient hospital deductible for a period of hospitalization which began in December 1989; and

-- Individuals in a spell of illness which started before January 1, 1990.

The **three day prior hospitalization requirement** does not apply to individuals receiving Medicare covered SNF services during a continuous period beginning before (and including) January 1, 1990, until the individual does not receive SNF or inpatient hospital care for 30 consecutive days.

Repeal of the extended **hospice care benefit** shall not apply to those individuals who elected, before January 1, 1990, to receive the period of hospice care provided in MCCA. For other beneficiaries, the prior limit of 210 days of hospice care applies.

o Termination of Transitional Adjustments in Payments for Inpatient Hospital Services

**For PPS hospitals**, the Secretary is required to take into consideration reductions in payments to hospitals by Medicare beneficiaries resulting from elimination of the day limitation on Medicare inpatient hospital services when determining outlier cutoff points and weighting factors under PPS for discharges occurring between October 1, 1988 and December 31, 1989.

**For PPS-exempt hospitals**, the Secretary is required to take into consideration the reductions in payments to hospitals by Medicare beneficiaries resulting from the elimination of the day limitation on Medicare inpatient hospital services when adjusting the target amounts for cost reporting periods between October 1, 1988 and December 31, 1989.

Effective Date

o Effective January 1, 1990.

**Repeal of Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund (Section 102)**

Current Law

- o Supplemental Premium - An annual supplemental premium is imposed on individuals who are eligible for Medicare Part A for more than 6 full months in a calendar year and whose federal income tax liability equals or exceeds $150 for the year. Supplemental premium rates are set in law for taxable years 1989 through 1993, and are set according to a formula established in the law for subsequent years. This premium is limited to a maximum annual amount per individual.

- o Federal Hospital Insurance Catastrophic Reserve Fund - Receipts from the supplemental Medicare premium are transferred (at least monthly) from the general fund to the Federal Hospital Insurance Catastrophic Reserve Fund. Transferred amounts equal 100 percent of outlays attributable to Part A catastrophic benefits.

Provisions

- o Supplemental Premium - The supplemental Medicare premium is repealed as if it were never enacted for taxable years beginning after December 31, 1988.

- o Federal Hospital Insurance Catastrophic Coverage Reserve Fund - The Federal Hospital Insurance Catastrophic Coverage Reserve Fund is abolished. Any balance in the fund as of January 1, 1990 is transferred to the Federal Supplementary Medical Insurance (SMI) Trust Fund.

- o Study Deadline Delayed - Delays until May 31, 1990 the deadline of the study to be conducted by the Secretary of the Treasury regarding Federal tax policies and the promotion of private financing of long-term care.

Effective Date

- o Effective January 1, 1990, except that the supplemental premium is repealed as if it never applied in 1989.

## TITLE II -- PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

### Repeal of Expansion of Medicare Part B Benefits (Section 201)

Current Law

- Beneficiary liability for Part B cost-sharing is limited to $1,370 in 1990. In future years, the cost-sharing limit is set at a level to ensure that 7 percent of Part B beneficiaries reach the limit. When the limit is reached, Medicare will pay 100 percent of reasonable charges for covered Part B services.

- Home intravenous drug therapy services including nursing, pharmacy, and related items and services necessary for the safe and effective administration of home IV drugs are covered by Medicare effective January 1, 1990.

- Expanded coverage of outpatient immunosuppressive drug therapy is covered by Medicare effective January 1, 1990.

- Routine mammography screenings are covered by Medicare, with certain limitations on the frequency of the procedure, beginning January 1, 1990.

- In-home respite care for up to 80 hours per calendar year for certain chronically dependent individuals is covered by Medicare beginning January 1, 1990.

- Daily home health care is covered for up to 38 consecutive days beginning January 1, 1990.

- Outpatient prescription drugs and insulin are covered, by Medicare, subject to a deductible and coinsurance, beginning January 1, 1991.

Provisions

- In general, Part B provisions enacted by MCCA are repealed. Current Medicare Part B benefits are those which were in effect on December 31, 1988. The following benefits were repealed:

  -- Limitation on Medicare Part B cost-sharing (the Part B "cap");

  -- Medicare coverage of outpatient prescription drugs and insulin (including provisions relating to the point of sale system, the Prescription Drug Payment Review Commission, and studies on various aspects of the Medicare outpatient drug benefit);

-- Medicare coverage of home intravenous drug therapy services including nursing, pharmacy services, medical supplies, intravenous fluids, delivery, and equipment;

-- Expanded Medicare coverage of outpatient immunosuppressive drug therapy;

-- Medicare coverage of mammography screenings;

-- Medicare coverage of 80 hours per year of in-home care for certain chronically dependent individuals (commonly known as "respite care"); and,

-- Expansion of Medicare home health services benefit (coverage of consecutive days of nursing care now reverts to the pre-MCCA limit of 21 days).

o Research on Long-Term Care Services for Medicare Beneficiaries and Study of Adult Day Care Services: study requirements are repealed.

o Exception for Diagnostic Coding Requirements - The provision requiring an appropriate diagnostic code on each bill submitted to Medicare for covered services or items furnished by a physician after March 31, 1989 is retained.

Effective Date

o Effective January 1, 1990.

**Conforming Amendment for Repeal of Expansion of Medicare Part B Benefits (Section 201(b))**

Current Law

o State Medicaid programs must buy-in Medicare coverage for the elderly and disabled whose incomes are at or below the specified percentage of the Federal poverty level. The Medicare outpatient prescription drug benefit is available to these individuals for whom the State buys-in to Medicare. States must pay the Medicare Part B premiums, coinsurance, and deductibles, including the annual deductible for covered outpatient drugs under the outpatient prescription drug benefit. States may elect instead to provide prescription drug benefits under Medicaid up to the amount of the Medicare drug deductible.

Provision

o Repeals the Medicare outpatient prescription drug benefit available to the elderly and disabled individuals for whom the

State buys-in to Medicare. Repeals the State option to provide prescription drug benefits under Medicaid up to the amount of the Medicare drug deductible instead of paying the annual deductible for covered outpatient drugs under the Medicare outpatient prescription drug benefit.

NOTE: States must still buy-in Medicare coverage for the elderly and disabled at or below the specified Federal poverty level and pay the applicable Medicare Part B premiums, coinsurance, and deductibles.

Effective Date

- January 1, 1990.

**Repeal of Changes in Medicare Part B Monthly Premium and Financing (Section 202)**

Current Law

- Part B Premium - To finance 37 percent of catastrophic health insurance benefits, a flat monthly Part B premium is imposed on Medicare beneficiaries enrolled in Medicare Part B. This additional premium is intended to cover 37 percent of the costs of catastrophic health insurance benefits. The flat premium was set at $4.00 in 1989.

- Drug Trust Fund and Catastrophic Coverage Account - Receipts from the supplemental Medicare premium and the Part B catastrophic premium attributable to prescription drugs are deposited into the Drug Trust Fund. All payments for benefits and administrative costs related to covered outpatient drugs will be made from the Drug Trust Fund.

  The Catastrophic Coverage Account is an accounting mechanism which tracks outlays and receipts attributable to catastrophic benefits, except outpatient prescription drugs. No funds are transferred into or out of this account.

Provisions

- Part B Catastrophic Premium - The catastrophic coverage monthly premium (which was effective January 1, 1989) and the prescription drug monthly premium (which would have been imposed beginning January 1, 1991) are repealed.

- Drug Trust Fund and Catastrophic Coverage Account - The Federal Catastrophic Drug Insurance Trust Fund and the Medicare Catastrophic Coverage Account are abolished.

- Exception for Hold-Harmless Provision - The "hold-harmless"

provision, which prevents most beneficiaries' Social Security payments from being reduced below the previous year's amount due to Medicare premium increases, is retained.

Effective Date

- January 1, 1990.

**Amendment of Certain Miscellaneous Provisions** (Section 203)

**Revision of Medigap Regulations**

Current Law

- Amended Standards -- MCCA 1988 amended procedures for Federal certification of Medigap policies. New National Association of Insurance Commissioners (NAIC) model standards, designed to eliminate duplication between Medigap policies and Medicare's catastrophic coverage, were adopted September 20, 1988. The new NAIC model standards also incorporated new consumer protection provisions contained in MCCA which required reporting of actual loss ratio data; submission of all advertising materials to the States; a 30-day free look period on all policies; and a piggyback billing provision contained in OBRA 87. In addition, the new NAIC model standards required actual attainment of the Federal loss ratio standards by the third year of a policy's life (as opposed to the expected loss ratio requirements of the statute).

- Effective Date of the New Standards -- MCCA provided that the new standards would apply for new Medigap policies in a State on the earlier of the date the State adopted standards equal to or more stringent than the revised NAIC model standards, or September 20, 1989, the nationwide effective date (one year after adoption by the NAIC).

- Transition Provision -- In September 1987, in anticipation of enactment of MCCA, the NAIC had adopted a separate transition rule to deal with in-force policies and sales using existing policy forms until the new standards could be put into effect. MCCA allowed in-force policies and existing policy forms which had qualified under the pre-MCCA standards and were issued in a State which had not yet adopted revised standards to continue to qualify under the new Federal standards if the insurer complied with the NAIC transition rule.

- Beneficiary Notices -- MCCA (and the NAIC transition rule) required insurers to notify beneficiaries of policy and premium change necessary to eliminate any duplication of Medicare's new catastrophic benefits. The NAIC transition rule required insurers to file with the State for appropriate

premium adjustments.

- Grace Period -- For policies issued in States where legislative action was required to implement the new standards but the legislature was not scheduled to meet during 1989, MCCA extended the transition period beyond September 20, 1989. This extension lasts until the beginning of the first quarter following the end of the firs legislative session that began on or after January 1, 1989.

Provisions

- Amended Standards -- Repeals none of the consumer protection provisions of MCCA. If NAIC revises the amended NAIC Model Regulation to reflect the changes made by MCCRA, the revised Model Regulation will become the basis for new Federal minimum standards.

  -- If the NAIC does not revise their amended Model Regulation to conform to the provisions of MCCRA within 90 days of enactment, the Secretary must issue revised Federal model standards within 60 days after the end of the 90 day period.

  The NAIC revised it Model Regulation on December 7, 1989, and made the adoption of the new standards effective with the President's signing the law on December 13, 1989.

  The revised NAIC standards require new policies to cover benefits removed in 1989 as duplicative to Medicare catastrophic coverage and to eliminate mandated coverage of the first 8 days of SNF coinsurance.

- Effective Date of New Standards -- The new standards apply in a State on the earlier of two dates: the date the State adopts standards that meet or exceed the revised NAIC standards, or one year after adoption of revised standards by NAIC (December 13, 1990) when the standards apply nationwide.

  -- On or after December 13, 1990, no Medigap policy may be certified by the Secretary under the voluntary certification program, no Federal certification shall remain in effect, and no State regulatory program shall be approved or remain approved by the Supplemental Health Insurance Panel unless the policy or State program meets or exceeds the standards set forth in the revised NAIC Model Regulation.

- Transition Provision -- Establishes a transition period for policies until States adopt new standards and a deadline of December 13, 1990 (one year from NAIC adoption of a revised Model Regulation). If a State adopts the new standards before

December 13, 1990, the transition period terminates in that State on the effective date of the new standards. Otherwise, a national transition deadline of December 13, 1990, applies for new sales of old policies.

Prior to the transition deadline, a Medigap policy is deemed to be in compliance if the insurer complies with the revised NAIC Model Regulation. After the deadline, policies must comply with the Model Regulation before the date of sale.

- Grace Period -- States which require legislation (other than legislation appropriating funds) for Medigap policies to meet the revised NAIC requirements, but where the legislature is not scheduled to meet in 1990, an extension of the transition period is granted until the first day of the quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990.

  -- In the case of a State that has a 2-year legislative session, each year shall be deemed to be a separate regular session of the State legislature.

- Beneficiary Notices -- Medigap policies in effect on January 1, 1990, shall not be deemed to meet Federal standards unless each Medicare beneficiary who is a policyholder on that date is sent a notice by January 31, 1990, explaining:

  -- the changes made by MCCRA; and,
  -- how changes made by MCCRA affect the benefits and premium of the Medigap policy.

  New sales using existing policy forms (prohibited after the transition deadline) must provide the notice prior to sale.

- Special Treatment for Dropped Policies -- A special transitional provision governs the reinstatement of coverage for beneficiaries who had Medigap coverage on December 31, 1988, but terminated their Medigap policies before the date of enactment of MCCRA, and who wish to re-enroll.

  -- Medigap Insurers Notices - In order to have their Medigap policies deemed to be in compliance with Federal standards, Medigap insurers must send written notices to all policyholders no earlier than December 15, 1989, and no later than January 30, 1990, providing them with the opportunity to re-enroll (with coverage effective as of January 1, 1990) under terms which:

    + do not provide for any waiting period for treatment of pre-existing conditions;

    + provide coverage substantially equivalent to coverage

in effect before the date of termination; and,

+ provide a classification of premiums which is at least as favorable to the beneficiary as the terms that existed prior to termination of coverage.

-- Enrollment Period - Insurers must offer an enrollment period of at least 60 days, beginning no later than February 1, 1990.

-- Medigap insurers are not required to reinstate coverage to policyholders if they obtained Medigap coverage from another insurer and if they are not subject to a waiting period for a pre-existing condition under that policy.

Effective Date

o Effective January 1, 1990.

**Adjustment of Contracts with Prepaid Health Plans**

Current Law

o MCCA requires the Secretary to modify contracts with risk-contracting HMOs and CMPs to reflect the new catastrophic requirements.

o Prepaid plans are required to adjust their agreements with beneficiaries, including appropriate adjustments in premiums and covered benefits.

Provision

o For CY 1990 only, risk contracting HMOs/CMPs must provide all MCCA benefits, including changes in beneficiary cost-sharing, that would have been provided in 1990 if MCCA had been implemented. These benefits include: unlimited inpatient hospital days; 150 days of SNF care (without a required prior hospital stay); limit on beneficiary Part B cost-sharing; expanded home health coverage; respite care; expanded hospice coverage, coverage for home intravenous drug therapy, expanded coverage of immunosuppressive drugs, and coverage of routine mammograms.

Effective Date

o January 1, 1990.

**Notice of Changes**

Current Law

- MCCA required that the Secretary distribute an annual notice to current beneficiaries (and a notice to new eligibles) that describes benefits covered and not covered under Medicare and limitations on Medicare payments (including deductibles and coinsurance).

Provision

- The Secretary is required to inform beneficiaries of the changes made by MCCRA in the 1990 Medicare Handbook.

Effective Date

- January 1, 1990.

**Miscellaneous Technical Correction**

Current Law

- The MCCA contains a technical drafting error with respect to section lettering in the section on advertising of Medigap policies.

Provision

- Corrects the technical drafting error.

Effective Date

- Effective as if included in MCCA.

**TITLE III - MISCELLANEOUS AMENDMENTS**

**Miscellaneous MCCA Amendments (Section 301)**

Current Law

- Maintenance of Effort - MCCA provided for a "maintenance of effort" provision requiring certain employers to provide additional benefits or refunds to beneficiaries equal to the value of the benefits in their plans which duplicated Medicare catastrophic coverage.

- Rate Reduction for Medicare Eligible Federal Annuitants - Federal Employees Health Benefits (FEHB) plans are required to reduce the rates charged to Medicare-eligible individuals by the amount of the estimated cost of medical services and supplies that duplicate benefits provided under MCCA.

- Study and Reports by the Office of Personnel Management (OPM) on Offering Medicare Supplemental Plans to Federal Medicare Eligible Individuals and Other Changes - MCCA required OPM conduct a study of changes to the FEHB program that may be required to incorporate plans designed specifically for Medicare-eligible individuals. (NOTE: OPM issued the study in April 1989.)

- Benefits Counseling and Assistance Demonstration Project for Certain Medicare and Medicaid Beneficiaries - MCCA required the Secretary to establish a 3-year demonstration project to train volunteers and provide benefits counseling and assistance concerning the Medicare and Medicaid programs to elderly persons.

- Case Management Demonstration - MCCA required the Secretary to establish by July 1, 1989, four demonstration projects for two years to provide case management services to Medicare beneficiaries with selected high cost illnesses.

- Advisory Committee on Medicare Home Health Claims - MCCA required the HCFA Administrator to appoint, within 90 days of enactment, an Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial rate for home health claims, the implications of such denials, and the possibility that reform is necessary. The Committee is to report its findings within 1 year of enactment.

Provision

- Repeals MCCA provisions related to maintenance of effort, FEHBP rebates, the OPM study of plans for Medicare-eligible individuals, benefits counseling and assistance demonstration project for certain Medicare and Medicaid beneficiaries, case management demonstration projects, and the Advisory Committee on Medicare Home Health Claims.

Effective Date

- January 1, 1990, except the repeal of the maintenance of effort provision does not apply to duplicative part A benefits for periods prior to January 1, 1990.

**Miscellaneous Technical Corrections**

Current Law

- The Omnibus Budget Reconciliation Act of 1986, Omnibus Budget Reconciliation Act of 1987, and the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, authorized several changes to Title XVIII of the Social Security Act.

Provision

- Makes miscellaneous technical corrections to provisions related to fee schedules for radiologist services, nonparticipating physician, capital-related costs, payment for hospital services, the patient outcome assessment research program, and Medicare sanctions.

Effective Date

- The provisions relating to miscellaneous technical correction shall take effect on enactment, except that the provision related to fee schedules for radiologists services is effective as if included in OBRA 87.

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